DOCUMENT RESUME

ED 319 177 EC 230 865

AUTHOR Swartz, Stanley L.
TITLE Evaluatinag Case Study Methods Used To Diagnose Behavior Disorders.
PUB DATE Nov 89
NOTE 19p.; Paper presented at the Annual Conference of Teacher Educators of Children with Behavioral Disorders (13th, Tempe, AZ, November 1989).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Research/Technical (143)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Behavior Disorders; *Case Studies; Educational Diagnosis; Elementary Secondary Education; *Eligibility; Evaluation Criteria; *Evaluation Methods; Preschool Education; *Referral; Special Education; *Student Evaluation; Student Placement
IDENTIFIERS Illinois

ABSTRACT

The case study method used to determine eligibility for referral to special education in Illinois is examined. Required case study components in Illinois include an interview with the child, consultation with the child's parents, social developmental study, assessment of the child's adaptive behavior, assessment of the child's cultural background, medical history/current health status, vision and hearing screening, academic history, assessment of current educational functioning and level of educational achievement, evaluation of learning processes, assessment of learning environment, and specialized evaluations, including speech/language and psychological, as needed. A total of 549 professionals were surveyed, including regular and special education teachers, administrators, psychologists, school social workers, and other practitioners. Respondents were asked to rate usefulness of the various case study components and indicate what professional should have primary responsibility for component completion. Overall ratings for usefulness of case study components were high. Highest ratings were for current educational functioning and psychological evaluation. In general, components that were psychoeducational and medical ranked as more useful than those that were sociological/environmental. Teachers, psychologists, and social workers emerged as primary diagnosticians. Modifications of case study components for different age levels and for variations in severity of behavior disorder are also examined. (JDD)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

ED319177

Evaluating Case Study Methods Used to Diagnose Behavior Disorders

Stanley L. Swartz
California State University
San Bernardino

Thirteenth Annual
Teacher Educators of Children with Behavioral Disorders
Conference on Severe Behavior Disorders of Children and Youth

Tempe, Arizona
November 1989

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Stanley L Swartz
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

EC230865

BEST COPY AVAILABLE

Introduction

The research literature is replete with the difficulties involved in diagnosing children with behavior problems (see, for example, Grosenick & Huntze, 1980; Walker & Fabre, 1987). Definition, identification, and measurement of behavior disorders in children are the focus of continuing debate in the field of special education (CCBD, 1984 & 1987). Definitional consensus for the behavior disorders category has not been established (Cullinan & Epstein, 1979; Epstein, Cullinan & Sabatino, 1977; Kavale, Forness & Alper, 1986) and even the issue of an appropriate label for this population is unresolved (Swartz, Mosley & Koenig-Jerz, 1987). Ongoing measurement issues include the inadequacy of assessment procedures and instrumentation (Ysseldyke and Algozzine, 1984), suitability of some personnel involved in the diagnostic process (Gresham, 1985), and the adequacy of teacher referral in terms of appropriateness or objectivity of data collected (Algozzine, Yesseldyke & Christenson, 1983).

In a survey of all fifty states and the District of Columbia, considerable diversity was found in methods used to identify the behavior disordered population (Swartz, et al., 1987). Three states had no referral and evaluation procedures and of the remaining forty-eight, procedures ranged from

---

This study was completed under a contract with the Illinois State Board of Education, Bobbie Reguly, staff consultant. Research team members included William Mosley, Robert Ristow, Linda Meloy and Kristy Wethington.

recommended to mandated and from very general suggestions to very specific stepwise requirements. The results of this study suggested the absence of any coherent notion of best practices in the evaluation of behavior disorders in children.

These general concerns regarding the evaluation process used to determine eligibility for special education and questions about the required case study used in Illinois set the stage for this study. The procedures required in Illinois for special education referrals were developed as an attempt to implement known best practices in the evaluation process. Illinois represented a good study opportunity because it has one of the most highly prescribed methods for special education evaluation. Required case study components and their operational definitions included the following:

1. An interview with the child - the purpose of the child interview is to obtain the child's perceptions related to the school, home, and community environments.

2. Consultation with the child's parents - the purpose of consulting with the parents is to ascertain the parents' perceptions and provide the parents with an opportunity to express their issues and concerns.

3. Social developmental study - the purpose of the social developmental study is to assist the educational team to understand the student, his/her in-school and out-of-school behaviors and how the many environments affect the student so that the team members may develop the best possible educational plan for the student.

4. Assessment of the child's adaptive behavior - a simplified definition of adaptive behavior is the effectiveness with which an individual functions independently and meets culturally imposed standards of personal and social responsibility.

5. Assessment of the child's cultural background - the purpose of the cultural background assessment is to determine how the student's culture or background affects the ability of a student to function in the school, as well as to determine if the school and community are responding to the child appropriately.

6. Child's medical history/current health status - the purpose of the review is to determine if there are health problems which contribute to the student's current educational problem, interfere with the student's learning processes, and/or require a change in the student's educational program.

7. Vision screening - all students being evaluated for special education services must have a vision screening completed at the time of the evaluation or within the previous six months.

8. Hearing screening - all students must have a hearing screening completed at the time of the evaluation or within the previous six months.

9. Review of child's academic history and current educational functioning - the purpose of reviewing the child's academic history is to determine if there is any pattern in the student's schooling which affects the child's ability to complete his/her current educational program.

10. Educational evaluation of the child's learning processes - learning process deficits can be observed by a teacher who systematically observes the areas of attention, discrimination, memory, multiple sensory integration, concept formation and problem solving.

11. Level of educational achievement - information on what a student has learned, how he/she processes information and the current amount of learned information.

12. Assessment of the child's learning environment - the intent of the learning environment assessment is to determine the level of match between a classroom environment and the particular student evaluated for potential placement in special educational programming.

13. Specialized evaluations - selected on an as-needed basis.

Speech and language - the purpose of the speech and language evaluation is to determine the degree and extent of oral language usage, receptively and expressively, and language processing abilities.

Medical examination - suspected physical, health, vision or hearing impairment.

Psychological evaluation - refers to the use of formal and informal data collection devices with individual children to obtain information which leads to knowledge of a child's learning rate and style and thus provides a basis for personalized instruction (23 Illinois Administrative Code 226).

Other specialized evaluations include: vocational, audiological, and evaluations to determine the need for occupational and physical therapy.

Method

Data specific to the case study procedures used were collected by surveying professionals involved in special education evaluation throughout the State of Illinois (N=549, 53 percent return). Respondents included: regular teachers (N=49), regular administrators (N=53), special education teachers (N=49), special education administrators (N-58), school psychologists (N=59), school social workers (N=59), speech and language therapists (N=50), school nurses (N=48), school counselors (N=42), audiologists (N=22), occupational therapists (N=33), and physical therapists (N=43). Respondents were asked to rate usefulness of the various case study components on a 1 (low) to 5 (high) scale and indicate what professional should have primary responsibility for component completion. In addition, respondents were asked what modifications should be made in case study requirements for children of different ages and severity of behavior disorder (mild or moderate).

Results

Respondents were asked to rate each of the required case study components on a 1 (low) to 5 (high) scale depending on their perception of how useful each component was in the identification process. Mean rating and standard deviations for usefulness of case study components for all respondents are listed in Table 1. Ratings ranged from a low of 3.61 for vocational evaluation to a high of 4.63 for current educational functioning.

Table 2 lists responses indicating those professionals who should have primary responsibility for completion of each case study component. Though considerable overlap is seen for some components, teachers, psychologists, and social workers emerge as primary diagnosticians. Other specialists were perceived as having more narrow areas of responsibility.

Table 3 lists mean ratings for usefulness for the primary diagnosticians; regular teachers, special teachers, school psychologists and school social workers. As might be expected, each group rated their own area of responsibility slightly higher. It should also be noted that the special education teacher was not indicated as the individual with primary responsibility for any of the case study components.

Listed in Table 4 are the recommended modifications, or those case study components that might be omitted for different age levels (preschool, elementary, junior high, and high school) and severity of behavior disorder (mild or moderate). Preschool

Table 1

Rating of Case Study Usefulness
(N=549)

	Mean rating	SD
Child interview	3.87	1.29
Parent consultation	4.52	.88
Social developmental study	4.24	1.04
adaptive behavior	4.14	1.08
cultural background	3.94	1.14
Medical history	4.45	.88
current health status	4.50	.86
Vision screening	4.38	.96
Hearing screening	4.40	.96
Academic history	4.50	.85
current educational functioning	4.63	.82
Evaluation of learning processes	4.46	.95
levels of educational achievement	4.44	.94
Assessment of learning environment	3.81	1.19
Specialized evaluations		
psychological	4.62	.85
medical	4.14	1.16
speech and language	4.35	.97
audiological	4.08	1.15
vocational	3.61	1.27
occupational therapy	3.77	1.28
physical therapy	3.80	1.27

Table 2

Primary Responsibility for Case Study Component Completion (N=549)

	Regular Teacher	Regular Admin.	Special Teacher	Special Admin.	Psychologist	Social Worker	Speech & Lang.	Nurse	Counselor	Audiologist	O.T.	P.T.	Physician
Child interview	26	3	20	3	55	44	9	4	20	4	4	4	3
Parent consultation	25	10	17	9	30	61	5	7	15	3	3	3	3
Social developmental study	4	0	3	1	10	71	1	2	6	0	0	0	0
adaptive behavior	0	1	6	1	18	62	1	2	6	0	2	1	1
cultural background	4	1	2	1	10	65	2	5	6	0	0	0	1
Medical history	1	0	1	1	3	12	2	65	1	4	3	4	27
current health status	2	1	1	1	2	8	1	58	1	2	1	1	23
Vision screening	1	0	1	1	0	0	2	83	5	4	0	5	14
Hearing screening	1	0	1	0	1	0	4	65	0	27	0	0	9
Academic history	48	10	25	4	18	5	1	0	13	0	0	0	0
current educational functioning	53	4	31	3	22	2	2	0	6	0	0	0	0
Evaluation of learning processes	25	2	32	5	56	2	2	4	3	1	1	1	0
levels of educational achievement	28	1	30	4	44	2	1	0	5	1	1	0	1
Assessment of learning environment	26	17	29	11	38	14	2	0	6	1	2	1	4
Specialized evaluations													
psychological	1	0	2	1	87	1	0	3	1	0	3	0	2
medical	1	4	1	0	1	2	2	37	1	2	2	2	63
speech and language	1	0	3	1	1	1	83	2	0	7	0	0	2
audiological	1	0	1	1	0	0	7	11	1	74	1	4	4
vocational	8	2	26	4	7	5	0	1	34	2	11	3	3
occupational therapy	0	0	1	0	0	1	0	1	0	1	82	4	3
physical therapy	0	0	1	0	1	0	0	1	0	1	5	76	6

Table 3

Rating of Case Study Usefulness
by Primary Diagnosticians

Mean ratings	reg tch	spec tch	psyc	soc work
Child interview	4.53	3.64	4.04	4.22
Parent consultation	4.56	4.29	4.44	4.71
Social developmental study	4.29	4.26	4.45	4.77
adaptive behavior	4.32	4.05	4.24	4.43
cultural background	4.08	3.90	3.94	4.29
Medical history	4.54	4.17	4.35	4.73
current health status	4.43	4.40	4.38	4.71
Vision screening	4.42	4.29	4.28	4.61
Hearing screening	3.94	4.33	4.25	4.65
Academic history	4.76	4.35	4.45	4.53
current educational functioning	4.70	4.62	4.57	4.71
Evaluation of learning processes	4.54	4.40	4.24	4.51
levels of educational achievement	4.48	4.45	4.53	4.36
Assessment of learning environment	4.06	4.87	3.52	3.87
Specialized evaluations				
psychological	4.50	4.43	4.80	4.77
medical	4.30	4.13	3.86	4.12
speech and language	4.15	4.17	4.45	4.30
audiological	4.00	3.91	3.94	3.90
vocational	3.46	3.43	3.32	3.66
occupational therapy	3.40	3.55	3.43	3.67
physical therapy	3.40	3.58	3.50	3.74

Table 4

Recommended Modifications of Case Study Requirements
(N=502)

	Age*				Severity**	
%	P	E	J	H	MILD	MOD
Child interview	27	17	8	9	11	10
Parent consultation	9	11	11	16	3	6
Social developmental study	4	3	7	9	2	1
adaptive behavior	2	3	1	1	3	3
cultural background	3	6	7	6	1	1
Medical history	0	1	2	1	2	3
current health status	1	2	1	3	2	2
Vision screening	1	1	2	3	3	4
Hearing screening	2	1	2	4	5	7
Academic history	16	12	3	4	3	2
current educational functioning	13	11	5	5	3	14
Evaluation of learning processes	6	7	4	4	2	4
levels of educational achievement	11	10	9	7	3	12
Assessment of learning environment	2	3	1	2	2	1
Specialized evaluations						
psychological	9	2	3	3	4	3
medical	0	1	2	2	0	3
speech and language	2	3	7	11	2	3
audiological	1	1	2	1	1	2
vocational	13	13	16	9	7	14
occupational therapy	12	14	21	20	17	18
physical therapy	16	19	20	19	13	16

* age levels: preschool, elementary, junior high school, and high school

** severity: mild, moderate

was the level most frequently suggested for case study modification. Modifications are listed for child interview, parent consultation, educational functioning and achievement, and the specialized evaluation areas of vocational and occupational and physical therapy.

Discussion

Overall ratings for usefulness of case study components were high. Highest ratings for current educational functioning and psychological evaluation suggest their importance in determining eligibility for special education. It is interesting to note that of four traditional assessment components (current educational functioning, psychological, educational achievement and learning processes), three were perceived as the responsibility of of the school psychologist. Evidently there is still a strong belief that information in these areas is best obtained by a school psychologist. Only current educational functioning was perceived to be an area where regular educators and special educators could collect information.

This traditional psychoeducational approach to evaluation is probably deeply rooted in the current concept of assessment. While many authors and some states are suggesting criterion referenced and curriculum-based assessments, professionals still perceive the need for specialized diagnostic services to be

provided by the school psychologist. Professionals want information about academic aptitude and achievement but also feel that data concerning how a child learns is important. However, either they do not feel competent in the collection of such data and thus rely heavily upon the school psychologist or there is still a strong belief in the value of intelligence testing as a measure of academic or school-based performance.

The impact of P.L. 94-142 can be seen in the high rating of parent consultation. Again, while many professionals rated this component as useful and important, the responsibility for collecting this data was given to the social worker and the school psychologist. It may well be that parent consultation is not really perceived as a sharing of experiences but rather as an assessment of the home environment. The intent of parent involvement outlined in P.L. 94-142 is to provide parents with input into their child's educational program and to develop a partnership between home and school. The heavy reliance on specialized personnel to obtain data from parents may not necessarily provide this. Of the direct educational service personnel involved in a child's program, the special education teacher was perceived as the least responsible. Perhaps special education teachers perceive themselves and are perceived by others as being too involved in the child's educational program to discuss parent input relative to assessment or, perhaps, as alluded to earlier, parent involvement is not perceived as a collaborative effort but as a means to assess the child's home

environment. It is interesting that the special education teacher was not perceived as having strong primary responsibility for any of the case study components.

Two other case study components that rated high were those of medical and academic history. The emphasis on these two areas supports the suggestion that the trend is still towards the more traditional evaluation methods. Special education and related service personnel still have a strong need to see the history of the child being referred. It was not surprising to find that the nurse was seen as the primary person responsible for collecting the medical data even though this could be supplied by the family physician. The present system used personnel outside the school only infrequently. Also not unusual was the focus on the regular educator to provide information on the academic history of the child. This reliance on the nurse for medical history and the regular teacher for academic history appears to be a simple case of assigning data collection responsibility to the professional closest to the data. Interpretation by the nurse is obvious, but what about the reliance on the regular teacher for interpretation of academic history. Perhaps, special education professionals perceive that regular teachers are more expert on the regular education curriculum and that they are needed to interpret this information. Or the simpler explanation is that the regular teacher must be involved in the evaluation process and this is one easy way to accomplish that involvement.

Questions relative to quantitative and qualitative measurements of a student's behavior are a continuing issue in the evaluation process. Concerns over cultural considerations, environmental constraints and validity/reliability measures often cause confusion and hesitation over the use of standardized measures for assessing adaptive behavior. These concerns are reflected in the survey results. Indeed, while the mean ranking for usefulness was high, twelve other components ranked higher. Sixty-two percent of the respondents indicated that the social worker had primary responsibility for collecting adaptive behavior information. This was also the case for cultural background and parent consultation. These three areas when linked to social development form the core of primary responsibility in the case study for the social worker. Aspects of the child that are considered outside the schools' domain (i.e., community) are evaluated by personnel typically based outside of the school.

Two of the required case study components rated lower than the others in terms of their usefulness; assessment of learning environment and child interview. Though the concept of the learning environment and its importance are probably well accepted, how to collect and use the information about it are less clear. Of primary diagnosticians, both the regular and special teachers have ranked it higher than the psychologists and social workers. Those who work in the environment obviously

think it is more important than those who don't.

The child interview also leads the list of case study modification recommendations. The interview was seen as less important for younger children. The importance of parent consultation diminished as the age of the child increased. This could reflect the overall increase of parent contact over time or it might reflect the child as a more independent information source in the higher grades. Current educational functioning and levels of educational achievement were also suggested for modification. This is probably related to perceived availability of data.

The specialized evaluations, occupational and physical therapy, were also identified as possible modifications. These are likely seen as areas unrelated to the typical behavior disorder. The inclusion of vocational evaluation as a recommended modification of the case study is less clear. Perhaps its relationship to program design rather than program eligibility resulted in this recommendation.

In summary, while all the components of the case study were rated as useful, those that were psychoeducational and medical ranked as more useful than those that were sociological/ environmental. The reliance on specialists, especially the school psychologist and social worker, for collecting and interpreting assessment data was noted. The apparent lack of inclusion of special educators in the assessment process was

disconcerting. Apparently, special education teachers are not perceived as an important part of the diagnostic team as it relates to the case study. This decision could contribute to less than efficient program planning. If it is related, as is suspected, to the ability to release the special teacher from classroom responsibility to participate in the evaluation process, such a consideration has no place in appropriate evaluation procedures.

The various components of the Illinois case study apparently have much to recommend them. Given the high overall rating and their consistent utility with the behavior disordered population, they can be recommended for general use.

References

Algozzine, B., Ysseldyke, J., & Christenson, S. (1983). An analysis of the incidence of special class placement: The masses are burgeoning. Journal of Special Education, 17, 141-147.

Council for Children with Behavioral Disorders. (1984). Position paper on substituting "behaviorally disordered" for "seriously emotionally disturbed" as a descriptor for children and youth handicapped by behavior. Reston: VA: CCBD, a Division of the Council for Exceptional Children.

Council for Children with Behavioral Disorders. (1987). Position paper on definition and identification of students with behavioral disorders. Reston: VA: CCBD, a Division of the Council for Exceptional Children.

Cullinan, D., & Epstein, M. (1979). Administrative definitions of behavior disorders: Status and directions. In F. Wood & K. Larkin (Eds.), Disturbing, disordered or disturbed? Perspectives on the definition of problem behavior in education settings. Minneapolis, MN: University of Minnesota, Advanced Training Institute, 17-28.

Education of the Handicapped Act, (1977). Washington, D.C.: Federal Register.

Epstein, M., Cullinan, D., & Sabatino, D. (1977). State definitions of behavior disorders. The Journal of Special Education, 11, 417-425.

Gresham, F. (1985). Behavior disorder assessment: Conceptual, definitional, and practical considerations. School Psychology Review, 14, 495-509.

Grosenick, J., & Huntze, S. (1983). National needs analysis in behavioral disorders: Severe behavioral disorders. Columbia, MO: University of Missouri, Department of Special Education.

Kavale, K., Forness, S., & Alper, A. (1986). Research in behavioral disorders/emotional disturbance: A survey of subject identification criteria. Behavioral Disorders, 11, 159-167.

Illinois State Board of Education, (1977). 23 Illinois Administrative Code 226. Springfield: Illinois.

Swartz, S., Mosley, W., & Koenig-Jerz, G. (1987). Diagnosing behavior disorders: An analysis of state definitions, eligibility criteria and recommended procedures. Paper presented ath the annual meeting of the Council for Exceptional Children, Chicago, Illinois. (ERIC Document Reproduction Service No. ED 284 384).

Walker, H., & Fabre, T. (1987). Assessment of behavior disorders in the school setting: Issues, problems, and strategies revisited. In N. Haring (ED.) Assessing and managing behavior disorders (pp. 198-234). Seattle: University of Washington Press.

Ysseldyke, J., & Algozzine, B. (1984). An introduction to special education. Boston, Houghton-Mifflin.